

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-003746

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. **318**
FILED JAN 25 1962

Primary Registration District No. **1003**

Registrar's No. **923**

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri		c. CITY OR TOWN St. Louis	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hosp. #1		d. STREET ADDRESS (If outside, give location) 4337 Maryland Ave.	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last Catherine Fitzgerald			4. DATE OF DEATH Month Day Year Jan. 19 1962			
--	--	--	---	--	--	--

5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5-30-1880	9. AGE (last birthday) 81 years	IF UNDER 1 YEAR Months Days 7 19	IF UNDER 24 HR Hours Min. 19
-------------------------	----------------------------------	---	--------------------------------------	---	---	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper	10b. KIND OF BUSINESS OR INDUSTRY retired	11. BIRTHPLACE (City and state or country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY U. S. A.
--	---	--	--

13a. FATHER'S NAME Augene Divine	13b. MOTHER'S MAIDEN NAME Margaret Murphy	14. NAME OF HUSBAND OR WIFE William F. Fitzgerald
--	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO.	17. INFORMANT Address Sr. Marie Jean, Supt., 3400 S. Grand Blvd.
--	-------------------------	---

18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia SEVERE Tracheobronchitis 501X		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
---	--	---

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
---	---	--

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
---	--	--	--

21. I attended the deceased from 12-30-61 to 1-19-62 and last saw her alive on 1-19-62 Death occurred at 2:35 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE John McLaughlin M.D. (Degree or title)	22b. ADDRESS 1515 Lafayette Avenue	22c. DATE SIGNED 1-19-62
--	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Jan. 22, 1962	23c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
--	-----------------------------------	--	--

24. FUNERAL DIRECTOR Gebken Sons	ADDRESS 2630 Gravois Ave.	25. DATE RECD. BY LOCAL REG. JAN 21 1962	26. REGISTRAR'S SIGNATURE Paul Smith M.D.
--	-------------------------------------	--	---

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 ITEM NO. SHOULD READ
 BY AFFIDAVIT OF

MEDICAL CERTIFICATION
 DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Robert T. Gilken

Licensed Embalmer No. 4144

P. O. Address St. Louis 18, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.